CHANGE REPORT

Michigan Department of Human Services

Grantee Name				
Grantee Client ID				
Case Number				
County	District	Section	Unit	Specialist
Local Office Name				
Local Office Address				

Use this form to **report changes about anyone in your home within 10 days** of the time you learn of them (For earned income, within 10 days of receiving your first payment.) If you cannot mail this form, report the change by calling your DHS specialist.

1. PERSONS IN YOUR HOME

List anyone who: • Was Born--Enter newborn's date of birth _____

• Died • Got Married or Divorced • Moved In or Out • Began or Ended a Pregnancy • Entered or Left a Nursing Home

• Is Temporarily Away From Your Home.

PERSON'S NAME	RELATIONSHIP TO YOU	AGE	WHAT WAS THE CHANGE?	DATE OF CHANGE

2. HOUSEHOLD INCOME

Did anyone: start working, have a change in rate of pay, change employers, have a change in the number of hours worked per week of more than 5 hours since last report that will continue for more than one month, stop working? **Did anyone:** start or stop getting Social Security, a pension, UCB, child support or other unearned income. Did the household's gross unearned income go up or down by more than $50 per month since your last reported change? If receiving Medicaid only (except for Healthy Kids), you must report a change in gross monthly unearned income of more than $25.

ATTACH a written statement SIGNED BY EMPLOYER, listing your work schedule (days and times) if you use day care and your work schedule has changed.

SEND PROOF OF INCOME: Include your name and case number on it so we may return it to you.

PERSON WITH INCOME CHANGE	TYPE OF INCOME	DID INCOME START, STOP OR CHANGE?	IS THE CHANGE EXPECTED TO CONTINUE? (Yes/No)	NUMBER OF EXPECTED HOURS OF WORK PER WEEK	HAS WORK SCHEDULE CHANGED?	AMOUNT RECEIVED?	HOW OFTEN IS INCOME RECEIVED? (Weekly, Bi-Weekly, Monthly, etc.)

3. WORK-RELATED ACTIVITIES

Did anyone participate in an approved employment-related activity, such as: Work First, high school completion, GED or college, etc.
ATTACH NEW CLASS SCHEDULE TO THIS FORM IF CHANGED.

LIST PERSON IN ACTIVITY	TYPE OF ACTIVITY	HAS CLASS SCHEDULE CHANGED? (Yes/No)	DID ACTIVITY START, STOP, OR CHANGE?	NUMBER OF HOURS OF EXPECTED PARTICIPATION PER WEEK

4. CHILD DAY CARE OR DISABLED ADULT CARE

Report any need for or change in child or disabled adult care such as changes in: need, days and times care is provided, provider changes, where care is provided, provider charges, etc. Do you receive help to pay for this care? ____ Yes ____ No

PERSON RECEIVING CARE	AGE	REASON FOR CARE(Work, School, Training, Medical/Social)	DATE OF CHANGE?	NAME OF THE PROVIDER	PROVIDER ID NUMBER
a.					
b.					
c.					
d.					

CHILD DAY CARE OR DISABLED ADULT CARE (continued)

PERSON RECEIVING CARE (List the same person as above)	DAYS AND TIMES CARE IS PROVIDED	IS CARE PROVIDED IN CHILD'S HOME?	IS PROVIDER RELATED TO THE CHILD	RATE CHARGED AND HOW OFTEN (Hourly, Daily, Weekly, etc.)	
a.				$	per
b.				$	per
c.				$	per
d.				$	per

5. ASSETS

Report if anyone has bought, sold, transferred, given away, or received any asset such as: bank accounts, land, cars, and other vehicles, boats, life insurance, investments, lawsuit settlements or any other property.

WHAT CHANGED?	PLEASE EXPLAIN THE CHANGE

6. OTHER CHANGES

Report if anyone has a change such as: address, rent, mortgage, taxes, insurance (home or health), utility costs, child support paid, medical expenses, school attendance.

PERSON WITH CHANGE	DATE OF CHANGE	PLEASE EXPLAIN THE CHANGE

7. Do you expect the changes you reported to continue next month? ☐ Yes ☐ No
If no, please explain below.

I understand that the information I provide on this report form may result in changes in my assistance, including reducing the amount of my checks (Cash Assistance, employment-related services and/or Child Development and Care), Food Assistance benefits and medical assistance, or closing my case. I understand that such changes may be made without advance notice. **I am aware that, if I give false information which causes me to receive assistance I am not entitled to, or more assistance than I am entitled to, I can be prosecuted for fraud.** I must report all changes in my situation within 10 days of learning of the change, or for earned income, within 10 days of the start date of employment.

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Client's Signature or Mark	Date	Client's Telephone Number
Signature of Other Person Completing Form or Witness	Date	

AUTHORITY: Act 280 of 1939, Food Stamp Act of 1977	COMPLETION: Voluntary	PENALTY: Loss of eligibility for assistance benefits
"The USDA is an equal opportunity provider and employer."	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, sexual orientation, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	